Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MANUEL RAMIREZ MD
CENTER FOR PAIN RELIEF
9080 HARRY HINES SUITE 110
DALLAS TX 75235

Respondent Name

CONTINENTAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-11-4095-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This MDR was previously submitted to the Texas Department of Insurance on 4/12/2011. We received two different responses from the carrier – see copies attached. One response indicated no payment would be issued and the other indicated a payment of $2,000.00 would be issued and a copy of the EOB, reflecting the payment issued, was attached. The payment of $2000.00 was issued on 5/09/2011. We received the payment and it was deposited into our account on 5/25/2011. When the payment was received in our office, I sent a withdrawal to TDI for our MDR." "On 5/31/2011 a stop payment on the check was issued by Bank of America. When we received the stop payment notification I contacted Lynnette Glover, the representative who signed the MFDR response from the carrier. She instructed me to contact the adjuster, Wonda Jackson to obtain information concerning the issue. I contacted Wonda Jackson and she responded saying that due to HIPPA reasons she could not discuss the issue with me. I then contacted TDI to see how to proceed with this issue and I was instructed to refile my original MDR."

Amount in Dispute: $2,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical fee dispute concerns reimbursement for pain pump refills between May 19, 2010 and January 5, 2011. The carrier submits that all fee reductions were made in accordance with the applicable fee guidelines. Medicare does not provide for reimbursement for the services underlying the disputed charges. No additional reimbursement is due. However, the merits of this dispute need not be considered given the requestor's failure to timely seek medical dispute resolution."

Response Submitted by: FOL on behalf of Continental Casualty Co., P.O. Box 201329, Austin TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 19, 2010 September 15, 2010 November 10, 2010 January 5, 2011	Pain Pump Refill - HCPCS Code J7799 KD	$500.00/day X 4 dates = $2,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 19, 2010
   - W1-Workers Comp state fee schedule adj reimbursement is based upon the max allowable fee for this proc code based upon the state medical fee schedule, or if not specified, usual, reasonable & customary for this geographic (zipcode) area.

   Explanation of benefits dated August 3, 2010
   - 16-Claim/service lacks info which is needed for adjudication. A valid NDC number, RX number, quantity and strength for drug is needed for reimbursement.

   Explanation of benefits dated September 9, 2010
   - W1-Workers Comp state fee schedule adj reimbursement is based upon the max allowable fee for this proc code based upon the state medical fee schedule, or if not specified, usual, reasonable & customary for this geographic (zipcode) area.

   Explanation of benefits dated November 3, 2010
   - W1-Workers Compensation state fee schedule adjustment. Payment for this service is excluded by Medicare payment policy regulation as adopted by TDI-DWC.

   Explanation of benefits dated January 3, 2011
   - W1-Workers Compensation state fee schedule adjustment. Payment for this service is excluded by Medicare payment policy regulation as adopted by TDI-DWC.

   Explanation of benefits dated January 31, 2011
   - W1-Workers Compensation state fee schedule adjustment. Payment for this service is excluded by Medicare payment policy regulation as adopted by TDI-DWC.

   Explanation of benefits dated March 28, 2011
   - 193-Original payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.

   Explanation of benefits dated May 6, 2011
   - W1-Workers Compensation state fee schedule adjustment.
   - This recommended payment is a result of your inquiry and is in addition to a recommendation previously made by the former bill review company.

Issues

1. Was the request for medical fee dispute resolution timely filed?
2. Did the requestor file the dispute in accordance with 28 Texas Administrative Code §133.307 (c)(2)(E)?
3. Did the requestor support position that billing is in accordance with Medicare policy?
4. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1)(A) states "Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. (1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The respondent states in the position summary that "…the merits of this dispute need not be considered given the requestor's failure to timely seek medical dispute resolution."

   The requestor states in the position summary that "This MDR was previously submitted to the Texas Department of Insurance on 4/12/2011. We received two different responses from the carrier – see copies attached. One response indicated no payment would be issued and the other indicated a payment of $2,000.00 would be issued and a copy of the EOB, reflecting the payment issued, was attached. The payment of $2000.00 was issued on 5/09/2011. We received the payment and it was deposited into our account on 5/25/2011. When the payment was received in our office, I sent a withdrawal to TDI for our MDR." "On 5/31/2011 a stop payment on the check was issued by Bank of America. When we received the stop payment notification I contacted Lynnette Glover, the representative who signed the MFDR response from the carrier. She instructed me to contact the adjuster, Wonda Jackson to obtain information concerning the issue. I contacted Wonda Jackson and she responded saying that due to HIPPA reasons she could not discuss the issue with me. I then contacted TDI to see how to proceed with this issue and I was instructed to refile my original MDR."

   The Division reviewed the submitted information and finds that the requestor submitted this request for dispute resolution on April 15, 2011. Once the respondent issued payment for the disputed services the requestor withdrew their request for dispute resolution. After the requestor withdrew the request for dispute resolution, the respondent stopped payment on the check. The Division concludes that the request for dispute resolution was timely filed in accordance with 28 Texas Administrative Code §133.307(c)(1).

2. 28 Texas Administrative Code §133.307 (c)(2)(E) states that the request for medical dispute resolution shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

3. The respondent denied reimbursement for the disputed services based upon "W1-Workers Compensation state fee schedule adjustment. Payment for this service is excluded by Medicare payment policy regulation as adopted by TDI-DWC."

   HCPCS code J7799 is defined as "NOC drugs, other than inhalation drugs, administered through DME."

   Trailblazers Health Enterprises published an article titled "Part B Drugs Used in an Implantable Infusion Pump" in August 2010. This article provided coding guidelines that indicate that "…compounded drugs used in an implantable infusion pump must be billed using Not Otherwise Classified (NOC) code J7799KD, whether a single drug or a combination of drugs is administered." A review of the submitted medical bill supports the requestor's position that HCPCS code J7799KD was billed in accordance with Medicare policy.

4. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other

payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203 (d)(1) (2)and (3) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

The Division finds that HCPCS code J7799KD does not have a fee listed in DMEPOS fee schedule nor a Medicare rate.

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1 which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- The requestor did not submit documentation to support that $500.00 per date is fair and reasonable.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. As a result, payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

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ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/30/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.